

# **Executive Summary**

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## **Hospital Emergency Department Use and Medicaid Clients**

In June 2013, the PRI committee undertook a study of emergency department (ED) use by Medicaid clients in Connecticut and what impact that might be having on the state Medicaid budget. The study was undertaken after discussions between PRI and leaders of the human services and appropriations committees. Concerns had been expressed about the frequent use of hospital EDs by Medicaid recipients, and whether there are adequate programs in the community to help prevent and divert people from ED use and obtaining access in more appropriate settings.

These concerns are heightened by the expansion of Medicaid to an increasing number of low-income residents through the Affordable Care Act (ACA), and whether there is an adequate network of medical professionals and other community providers to meet what will likely mean increasing demand for services.

### **Overall Use of Emergency Departments**

There were more than 1.75 million visits to hospital emergency departments by the general population in Connecticut in 2012. The vast majority of persons are seen and discharged, with only about 15 percent requiring an inpatient admission. While Connecticut's overall hospital emergency department use is somewhat higher than the national average, it is lower than any of the other New England states.

The study found that the number of emergency department visits by commercially insured Connecticut residents has declined by about 30,000 visits since 2007, and the percentage of overall visits by clients with private insurance has dropped from 41.8 percent of the population to about 31 percent in 2012. However, because the number of people with private insurance has also declined, the overall rate of ED visits per 100 with commercial insurance has remained fairly constant at about 18.5.

### **Medicaid Use of Emergency Departments**

Based on DPH data, the number of Medicaid visits to the ED has increased from 519,312 in 2010 to 589,260 in 2012. Visits by Medicaid clients in 2012 accounted for the greatest percentage of overall visits by payer source, at 36 percent. However, since the Medicaid population has also grown, and the rate per 100 has actually declined somewhat from about 116 to 106 visits between 2010 and 2012. Thus, on average there is more than one visit for every Medicaid recipient, over three times the rate of the rest of the population.

Although the average number of ED visits by Medicaid clients is high, more than half of Connecticut Medicaid recipients did not visit an ED at all during 2012. However, when data are examined across the four Medicaid populations in Connecticut, not surprisingly the HUSKY D program that serves low-income adults, many of whom were formerly SAGA clients, had the highest rate with 184 visits for every 100 clients. Further, if a HUSKY D client visited the ED, that client had an average of 2.72 visits. This was surpassed by HUSKY C clients -- which serves

older and disabled clients -- who, if they had an ED visit during 2012, went to the ED an average of 3.3 times.

Costs of overall ED use in the Medicaid program totaled \$229 million, which is only about 3.8 percent of the approximate \$6 billion state Medicaid budget. The cost per ED visit, excluding ambulance, was about \$350 for the entire Medicaid population. However, the cost per client with an ED visit was substantially higher, ranging from an average per client cost of \$439 in HUSKY B to an average of \$1,518 for each HUSKY C client with an ED visit.

While the majority of Medicaid clients who visited the ED in 2012 went only once, a small percentage of Medicaid clients had 10 or more visits during 2012, and 865 of those had 20 or more visits. The vast majority of Medicaid clients, including frequent users, had a *primary* diagnosis of a medical condition, with only six percent of visits coded as primarily behavioral health and two percent as alcohol-related.

However, when both the *primary and secondary diagnoses* codes were captured for adults, the secondary diagnosis of behavioral health or alcohol-related were the top five diagnostic codes and accounted for 20 percent of those with a secondary code. Those data seemed to support more closely what emergency department doctors indicated to the PRI committee and staff about what they were experiencing with clients, especially frequent users of the ED.

### **Alternatives to Emergency Department Use**

It is important that Connecticut ensure that there are alternatives to emergency department care for Medicaid clients, especially as the state gears up for a substantial expansion of the Medicaid population through the federal ACA. Compared to national statistics, Connecticut appears to have an adequate supply of physicians, including primary care providers and other mid-level providers like physician assistants and APRNs to address the health needs of the state's overall population. However, that assessment is based on ratio of the supply for the overall population, and does not address how many of those providers are available to serve Medicaid clients.

The ACA has increased the Medicaid rates for primary care providers to the Medicare levels and makes them fully federally reimbursable for two years. This provision has prompted a substantial increase in the number of providers who are enrolled in Medicaid, with the number of primary care physicians increasing by more than 1,000 and the number of other providers almost tripling, from 260 to 777, over the past two years. Other ACA provisions, like offering financial enhancements for primary care providers who manage and coordinate a patient's care, known as patient centered medical homes (PCMHs), will also help. However, data on Medicaid clients show that only about 60 percent of recipients overall are "attributed" or linked to a primary care provider, even fewer to a PCMH. The PRI committee believes the ASOs that are contractually obligated to ensure Medicaid clients are accessing care at the appropriate level should be more diligent in its efforts to make those connections.

Providers might also be more willing to accept Medicaid recipients if client eligibility in the program were more stable for a determined period of time. It is a deterrent for a provider to

accept Medicaid clients if at the time of the appointment, or later when a claim is submitted, the provider finds the client's eligibility has been discontinued. The Centers for Medicare and Medicaid Services (CMS) are promoting continued eligibility for children and adults under the expansion of Medicaid under ACA, and the program review committee recommends that Connecticut adopt that strategy.

One of the ongoing problems in Medicaid has been the lack of access to specialists in the program. Medicaid rates for specialist visits have historically been only a fraction of what Medicare pays, and while Connecticut's payments are somewhat higher (79 percent) than the national average of Medicaid-to-Medicare ratio of 70 percent, the rates are still a problem in getting a Medicaid client in to see a specialist. Many states are facing the same problem and are developing strategies, like "telehealth" and "telemedicine", which use technology as a substitute for face-to-face client appointments to deal with access to specialists. The Connecticut legislature in 2012 statutorily authorized DSS to establish a demonstration project at federally qualified health centers to pilot this effort but the department has not yet done so, and thus that DSS effort should be legislatively mandated.

Increases in primary care management, enhanced patient-centered care, continuous Medicaid eligibility to promote enrollment stability, and expanding ways that Medicaid clients can access specialty care should help mitigate use of emergency departments for care that could be provided in a community setting. However, some Medicaid clients need even greater assistance managing their health care.

There are a number of programs operated by the various Medicaid administrative services organizations and other organizations to provide intensive case management (ICM) services to different Medicaid populations, depending on the population category and service needs. All the ICM programs showed positive outcomes to varying degrees. The program review committee concludes, however, the more successful initiatives, especially for frequent users of the ED who have behavioral health or substance abuse disorders, are associated with ICM programs that:

- have more face-to-face client interaction;
- involve emergency departments in the selection of clients, and in the development of a care plan;
- perform ongoing, and not episodic, monitoring of clients' stability and progress, including frequent meetings of providers involved in client care and services; and
- demonstrate a persistence in engaging the client and managing health and psycho-social needs.

The study report makes a number of recommendations to help achieve these components to intensive case management, including co-location of ICM staff at hospital EDs with high frequent user populations.

Finally, the study focused on another group who reportedly are frequent users of the ED, those seeking controlled prescription drugs, like OxyContin. While no hard data exists on the

extent of the problem in Connecticut or the degree to which it involves Medicaid clients, ED physicians indicate it is a persistent issue.

Connecticut has a prescription drug monitoring program for controlled substances maintained by the state Department of Consumer Protection. All licensed physicians and pharmacists, including ED physicians, can access this system to determine the extent of the presenting patient's use of controlled prescription drugs. The American College of Emergency Physicians has developed a set of guidelines that include, among other steps, the use of state monitoring programs by ED physicians. At this juncture, PRI proposes that ED physicians follow the ACEP guidelines rather than imposing strict practice regulations as a few other jurisdictions have done.

The committee makes a total of 13 recommendations aimed at better educating Medicaid clients about alternate and more appropriate settings to get health care rather than visiting the emergency department is proposed, a more active approach to ASO-attribution or linking Medicaid clients to primary care providers, especially PCMHs. For clients who need intensive case management, more face-to-face client interaction by ICM staff, especially at the ED, and better coordination of ICM services is proposed. While the committee acknowledges it should not be the responsibility of ED doctors and staff to ensure that frequent users of the ED are receiving adequate services in the community, it is important that ICM staff attempt to involve the ED staff in addressing the issues affecting client recidivism at the ED. The 13 recommendations are:

- 1. The Department of Social Services should develop brochures about alternatives available to the emergency department if a client does not need immediate attention. The brochures should be distributed and made available to clients at federally qualified health centers and primary care offices, including those enrolled as patient centered medical homes, with high Medicaid patient caseloads.**
- 2. The Department of Social Services shall require its Medicaid contractor with access to complete client claim adjudicated history, to analyze and report on Medicaid clients use of the emergency department on an annual basis, and the report should include, at a minimum:**
  - **a breakdown of the number of unduplicated clients visiting an emergency department by range; and**
  - **for those clients with 10 or more annual visits to any hospital:**
    - **the number of visits categorized into specific ranges as determined by the department;**
    - **time and day of visit;**
    - **the reason for the visit;**
    - **if the client is attributed to a primary care provider;**
    - **if the client had an appointment with a community provider within 30 days after the visit; and**
    - **the cost of the visit.**

**The department should use this report to monitor contractor performance, particularly with linking frequent users of emergency departments to primary care providers within a 30-day timeframe following an ED visit. In addition, the report shall be provided to the Council on Medical Assistance Oversight.**

- 3. The Department of Social Services shall require the administrative services organizations to conduct the mystery shopper survey of primary care providers and specialists, including whether the providers are accepting new patients, and wait times for appointments for new and existing clients to measure ease of access, as required in the administrative service organization contracts.**
- 4. Once a person is determined eligible for Medicaid and the ASO is notified of the eligibility, the ASO should contact the member to provide information about primary care providers in their geographic area accepting Medicaid clients. Further, the ASO should inform the client of the advantages of the PCMH – like extended hours, urgent care, and same-day appointments – and offer to work with the client to make that primary care connection.**
- 5. Once a Medicaid client has been attributed to a primary care provider, that provider's name and contact information should be printed on the Connect (Medicaid) card issued (or reissued at redetermination) to the client.**
- 6. Statutorily adopt a 12-month continuous eligibility provision for children during the 2014 legislative session. Further, DSS shall immediately seek an amendment to its 1115 waiver from the Centers for Medicare and Medicaid Services to implement 12-month continuous eligibility for all adult Medicaid recipients.**
- 7. the statute be modified to mandate that by January 1, 2015 DSS engage in a demonstration project as authorized in P.A. 12-109 and that at least one demonstration project reimburse for specialist services delivered by a telemedicine or telehealth model. The department should file any Medicaid state plan amendments with CMS necessary to implement the project. The commissioner shall submit a report, including the cost effectiveness of the program, and whether it should be extended to other areas of the state, to the legislature's appropriations and human services committees.**
- 8. The Department of Social Services monitor its administrative services organizations' reporting requirements to ensure all contractually obligated reports, including the Emergency Department Provider Analysis Report by ValueOptions, are issued as required.**

9. The Department of Mental Health and Addiction Services, in conjunction with DSS financial staff and the Office of Policy and Management, ensure that expenditures for all intensive case management services eligible for Medicaid reimbursement be submitted to the Centers for Medicare and Medicaid Services.
10. DSS and DMHAS should contractually require that the intensive case management teams of CHN-CT, ValueOptions and ABH: identify hospital EDs for the program based on the number of frequent users; and engage ED staff of the relevant hospitals in helping to identify Medicaid clients who would benefit from this community care intensive case management.

DSS and DMHAS should contractually require that at least one staff member from the regional intensive case management teams be co-located at hospital EDs participating in the program, at hours when frequent users visit the most and when ED use is highest.

11. These ICM staff should:

- work with ED doctors to develop a care management plan (and accompanying release of information) for clients who agree to participate;
- be knowledgeable about the community services and providers in the area;
- serve as liaisons between the hospital ED staff and the community providers identified in the client’s care plan; and
- meet weekly with providers to monitor clients’ progress.

12. Emergency department physicians, should, as a first step follow ACEP guidelines, which includes checking the state’s prescription drug monitoring program, prior to prescribing controlled prescription drugs to a patient in the ED.
13. The CMS strategies bulletin should be circulated among the Program Integrity and Pharmacy Management staff of the Department of Social Services. In addition, the Office of Quality Assurance shall identify Medicaid clients who are outliers in the state’s Prescription Drug Monitoring Program and refer these clients to the review team to determine whether these clients should be placed on the Medicaid prescription restriction program.